TASC

Technical Assistance and Services Center

Flex Program Hour Highlights

Date: *September 27, 2000*
Topic: *Flex Program Tracking Project*
Facilitator: *Ann Miller, TASC*
Guests: *Amy Hagopian, WWAMI*
John Gale, University of Southern Maine
Stephanie Poley, University of North Carolina

State Flex Program Tracking Project partners are Project HOPE, RUPRI, University of Southern Maine, University of Minnesota, University of North Carolina, and WWAMI. Each research center has taken the lead in a different area of the program: RUPRI is responsible for communication dissemination, Project HOPE focuses on EMS, Maine tracks state experience, and Minnesota monitors the hospital conversion experience. North Carolina and WWAMI have been involved in other types of data collection.

The State Flex Program Tracking Project's first year report will soon be available on their web site (www.rupri.org/srhf-eval/). During the first year of the program evaluation, the team visited 12 states and 24 CAHs and the conclusions summarized in their report were based on those visits.

Amy Hagopian summarized some key factors that predicted success of conversion process, which included: community support, help from state agency, help from network hospital, and a focus on ER as portal to the community.

Other findings include:

- This program has caused strengthening of relationships with other rural health organizations.
- Quality assurance has resulted in structural changes they will continue to monitor. The QA was onerous as a requirement, but hospitals felt their quality was being improved.
- Conversion has not been a "silver bullet" to solve all problems endemic to small, rural hospitals.
- Barriers to successful implementation of the program have been found to be getting Medicaid to participate, the lab reimbursement problem, FIs not being prepared to implement program, and the EMS fee schedule.
- The team will be gathering data about how accurate the feasibility studies have been. There is a huge variety of types of studies that were done.

John Gale summarized the "state experience." The tracking team looked at a wide variety of experiences and each state varies in how they approached the program. It has not been the tracking team's intention to criticize any one approach. SORHs have various levels of experience in dealing with hospitals. The EACH/RPCH states had much more experience in dealing with the hospitals.

The states have had very little experience with the CAH program so far, less than a year, and when the site visits took place, things were just starting to fall into place. The number of conversions by state seems the easiest way to get some idea of success, but it not an accurate picture. Looking deeper into the state programs will more correctly reflect the program's success.

Other findings include:

- Linkages with State Hospital Associations has been very helpful.
- There is a large variability in states identifying eligible hospitals and defining the types of hospitals that should participate.
- Some states have tied their Flex Program dollars into state rural health services that might otherwise be in trouble.
- There has been an improvement in networking relationships in rural health players.
- States were not prepared for the competitive nature of the Flex Grant process.

Stephanie Poley reported the current data which she collects via e-mail from the states on a monthly basis. There are 44 approved state rural health plans, 1 is waiting for HCFA approval, 3 are in draft, and 2 not eligible to participate.

Other data collected:

- 254 CAHs in 31 states
- 1100 potential CAHs
- 400 have expressed interest in converting
- 92% of CAHs are in HPSA or MUA
- 90% are in counties high in Medicare eligibility
- Medicaid CBR states = 12 Inpatient, 13 Outpatient

Year Two Preview

- EMS and the Flex Program
- CAH market share data
- CAHs and networks
- CAHs and scope of services
- CAHs and quality
- Financial impact on converted hospitals
- Financial impact on Medicare program
- Community development
- Hospital administrative quality and results
- Policy goals at state level
- Flex Program MIS
- Physician relationship to CAHs
- Site visits to 8 states and 16 CAHs